LEA: ______________________

Occupational Therapy Progress Notes

Student Name:	Medicaid #:	Month / Year:

Short-term Goals with achievement dates

1. The student will
2. The student will
3. The student will
4. The student will
5. The student will
6. The student will
7. The student will

Treatment Log

Date	*Type of Contact	Short Term Goals Addressed	Therapeutic Activity	Student response to treatment (must be measurable)	Initials
			☐Visual Motor Ex. ☐Strengthening ☐ADL's ☐Coordination ☐Positioning ☐Equip. Use ☐Oral / Feeding ☐SI ☐Instruction of Staff / Caregiver ☐_______________________		
			☐Visual Motor Ex. ☐Strengthening ☐ADL's ☐Coordination ☐Positioning ☐Equip. Use ☐Oral / Feeding ☐SI ☐Instruction of Staff / Caregiver ☐_______________________		
			☐Visual Motor Ex. ☐Strengthening ☐ADL's ☐Coordination ☐Positioning ☐Equip. Use ☐Oral / Feeding ☐SI ☐Instruction of Staff / Caregiver ☐_______________________		
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*** Type of Contact: I = Individual G =Group SA = Student Absent TA = Therapist Absent**
U = Unavailable C = Communication w/ parent or professional (not billable)

______________________________ ______________________________ ______________
Therapist/Asst. Therapist Signature & Title Therapist/Asst. Printed Name & Title Initials

______________________________ ______________________________ ______________
Supervising Therapist Signature & Title Supervising Therapist Printed Name & Title Initials

Student Name:	**Medicaid #**	**Month / Year:**

Date	***Type of Contact**	**Short Term Goals Addressed**	**Therapeutic Activity**	**Student Response to Treatment (must be measurable)**	**Initials**
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